

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **13141**

FILED MAY 6 1953

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>159</u>	
1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair			
b. CITY (If outside corporate limits, write RURAL and give township) Kirksville		c. LENGTH OF STAY (in this place) 60 Years		c. CITY (If outside corporate limits, write RURAL and give township) Kirksville		0013	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2011 South First St.				d. STREET ADDRESS (If rural, give location) 2011 South First St.			
3. NAME OF DECEASED (Type or Print) Jessie		a. (First)		b. (Middle) Guthrie		c. (Last) WILCOX	
4. DATE OF DEATH (Month) (Day) (Year) April 30, 1953		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH May 5, 1872		9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Samuel N. Guthrie		13b. MOTHER'S MAIDEN NAME Lydia Mirts		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mildred Burns - Kirksville, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angina Pectoris. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized 10 years DUE TO (c) Coronary insufficiency. 5 years II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 16, 1944 , to Apr 30, 1953 , that I last saw the deceased alive on Mar 19, 1953 , and that death occurred at 6:00 a.m. , from the causes and on the date stated above.							
23. SIGNATURE Spencer L. Freeman M.D.		(Degree or title)		23b. ADDRESS Kirksville, Mo.		23c. DATE SIGNED 5-2-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 2, 1953		24c. NAME OF CEMETERY OR CREMATORY Llewellyn Cemetery		24d. LOCATION (City, town, or county) (State) Kirksville, Mo.	
DATE REC'D BY LOCAL REG. 5-4-53		REGISTRAR'S SIGNATURE Wate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paula Davis - Kirksville, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Guy J. Shelton

Licensed Embalmer No. 4700

P. O. Address Kirkville, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.